CENTRAL ISLIP SCHOOL DISTRICT

AUTHORIZATION FOR MEDICATION ADMINISTRATION IN SCHOOL

(To be completed by parent/guardian **and** medical prescriber)

Part A (Completed by MD or LHCP)

Student Name___________________________ DOB_________ Grade/Teacher______________

MDI (Inhalers)

Diagnosis______________________Medication________________________Dosage_________________

Frequency________________Time_____________Route____________Duration____________________

Is the MDI needed before Gym/Exercise? ________YES _________NO

Can medication be skipped for field trips? __________YES _________NO

Side Effects____________________________Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY

(Student Should Be Able to Self-Carry for Sports)

The self-directed student may carry their own inhaler/epipen/other medication? ______Yes ______No

**The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, purpose, and schedule. Student must demonstrate responsibility.

OTHER MEDICATIONS

Diagnosis__________________Medication________________________Dosage_________________

Frequency_________________Time____________Route_____________Duration_________________

Can medication be skipped for field trips? __________YES _________NO

Side Effects____________________________Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY

(Student Should Be Able to Self-Carry for Sports)

The self-directed student may carry their own inhaler/epipen/other medication? ______Yes ______No

**The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, purpose, and schedule. Student must demonstrate responsibility.

Diagnosis___________________Medication_______________________Dosage_________________

Frequency_________________Time____________Route_____________Duration________________

Can medication be skipped for field trips? __________YES _________NO

Side Effects____________________________Discontinue with Symptoms ____Yes ____No

INDEPENDENT USE AND CARRY

(Student Should Be Able to Self-Carry for Sports)

The self-directed student may carry their own inhaler/epipen/other medication? ______Yes ______No

The school nurse will assess the student based on the following criteria: able to identify medication by name, color, dose, time, **purpose, and schedule. Student must demonstrate responsibility.

____

MD /LHCP Signature____Date____________________

MUST **STAMP WITH NAME, ADDRESS, PHONE NUMBER**

Part B (Parent/Guardian)

I give permission for my child _______________________DOB__________ Grade/Teacher______ to be given medication prescribed by the Licensed Health Care Provider **(LHCP).** The medication will be provided in an original labeled container. I, the parent/guardian, authorize the school to assist my child in taking this medication. I agree that I will not hold liable any member of the school staff of official capacity assisting my child.

Signature of Parent/Guardian: ______________________________________ Date: ___________________

Parent/Guardian Contact Numbers:

(H)___________________________(C) __________________________ (W) ____________________

Parent/Guardian Permission for Independent Use and carry

I agree that my child may carry and use this medication independently at school or any school sponsored activity. Staff intervention/support is needed only during an emergency.

Signature of parent/Guardian: __________________________________ Date: ____________________